

project is to collect data on the conditions surrounding and preceding the onset of a problem. The data must be collected in a timely fashion so that information can be used to develop prevention and control techniques, to interrupt disease transmission and to help identify the cause of an outbreak. Since the events necessitating the collections of information are of an emergency nature, most data collection is done by direct interview or written questionnaire and are one-time efforts related to a specific outbreak or circumstance. If during the emergency investigation, the need for further study is recognized, a project is designed and separate OMB clearance is required. Interviews are conducted to be as unobtrusive as possible and only the minimal information necessary is collected. The Emergency Epidemic Investigations data collection project is the principal source of data on outbreaks of infectious and noninfectious diseases, injuries,

nutrition, environmental health, and occupational problems.

Each investigation contributes to the general knowledge about a particular type of problem or emergency, so that data collections are designed taking into account knowledge gained during similar situations in the past. Some questionnaires have been standardized, such as investigations of outbreaks aboard aircraft or cruise vessels.

The Emergency Epidemic Investigations data collection project provides a range of data on the characteristics of outbreaks and those affected by outbreaks. Data collected include demographic characteristics of the affected population, exposure to the causative agent(s), transmission patterns, and severity of the outbreak. These data, together with trend data, may be used to monitor the effects of change in the health care system, plan health services, improve the availability of medical services, and assess the health status of the population.

Users of the Emergency Epidemic Investigations data include, but are not limited to, Epidemic Intelligence Service (EIS) officers of the CDC, who investigate the patterns of disease or injury, the level of risky behaviors, causative agents, the transmission of the condition, and the impact of interventions. EIS is a two-year program of training and service in applied epidemiology through CDC, primarily for persons holding doctoral degrees.

Predicting the number of epidemic investigations that might occur in any given year is difficult. The previous three years' experience shows an annualized burden of 3,750 hours and respondent total of 15,000. After completion of the Epi-Aid investigation, using the Epi-Aid Satisfaction Survey for Requesting Officials, data are collected from 100 state and local health officials for an annualized total of 25 burden hours. For this clearance, CDC is requesting 3,775 total burden hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Requestors of Epi-Aids	Epi-Aid Satisfaction Survey for Requesting Official.	100	1	15/60
General Public	Emergency Epidemic Investigations	15,000	1	15/60

Dated: November 13, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity (OSI), Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-13-13BU]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of

the data collection plans and instruments, call 404-639-7570 or send comments to Ron Otten, 1600 Clifton Road, MS D-74, Atlanta, GA 30333 or send an email to omb@cdc.gov.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Determining Causes of Sudden, Unexpected Infant Death: A National Survey of U.S. Medical Examiners and Coroners—New—National Center for Chronic Disease Prevention and Health

Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Each year in the United States, approximately 4,200 infants die suddenly without any cause that is immediately obvious. Half of these sudden unexpected infant deaths (SUID) are attributed to Sudden Infant Death Syndrome (SIDS), which is the leading cause of death in infants between one and twelve months of age. Reducing deaths caused by SIDS and other SUID such as accidental suffocation are important public health priorities.

Between 1990 and 2001, the rate of SIDS in the U.S. decreased from 1.3 per 1,000 live births to 0.56 deaths per 1,000 live births. The 50% decline in SIDS is attributed to the success of the "Back to Sleep" campaign, launched in 1994, during which prone sleeping for infants decreased from about 75% in 1992 to 12% in 2002. SIDS has continued to decline slightly and in 2009 was estimated to be 0.525 deaths per 1,000, however, post-neonatal mortality due to other causes increased, particularly in 1999-2001. Further examination of the cause-specific age at death and month of

death distributions suggested that cases once reported as SIDS were subsequently being reported as accidental suffocation and strangulation in bed or as cause unknown/ unspecified. Because SIDS, by definition, is nonspecific, there is substantial variation in how these deaths are reported by the medical examiner or coroner in the jurisdiction of record. Some variation in the classification of infant deaths may be due to inconsistent use of terms and definitions, and some variation may reflect limitations of investigation and documentation. Uncertainties in classification negatively impact understanding of the causes of infant mortality and the ability to develop appropriate public health responses.

CDC requests OMB approval to conduct the first national, geographically representative survey of medical examiners and coroners that concerns SUID diagnostic and reporting practices. Information will be collected to elucidate how medical examiners and coroners interpret and report SUID and the extent to which their interpretation and reporting practices vary. The

proposed activity is part of CDC's mission, as described in Section 241 of the Public Health Service Act [42 U.S.C. 241].

CDC's data collection contractor will draw a sample of medical examiners and coroners as follows. First, U.S. counties will be selected (with replacement) with probability proportional to the number of SUID-related deaths reported from 2005–2009. A sampling frame will be established for each county and the appropriate number of names will be randomly selected from the list. An interviewer will telephone approximately 800 offices to verify the name and contact information of the individual responsible for certifying infant deaths. Paper questionnaires will then be distributed to approximately 80 medical examiners and 720 coroners by mail. CDC expects to receive approximately 64 completed questionnaires from medical examiners and 576 completed questionnaires from coroners.

Questionnaires will take about 30 minutes to complete and will contain questions about each respondent's reporting jurisdiction, reporting

practices and training, knowledge and opinions about topics related to sudden unexpected and unexplained infant death, demographic characteristics, and jurisdiction-specific training and resource needs. Respondents will also review hypothetical infant death case descriptions and indicate how they would classify the cause of death for those cases. The questionnaire does not request the respondent's name, and response data will be de-linked from the information used for recruitment purposes. Data analysis will be conducted using de-identified responses.

Survey findings will be used to develop educational publications and presentations aimed at improving the consistent use of standardized terms and definitions in determining the cause of unexpected infant deaths. Findings may also be applicable to the development of public health programs aimed at reducing unexpected infant deaths.

OMB approval is requested for one year. Participation is voluntary and there are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)	Total burden (in hr)
Receptionist or Operator	Telephone Screener	800	1	5/60	67
Medical Examiner	National Survey of Medical Examiners and Coroners.	64	1	30/60	32
Coroner	National Survey of Medical Examiners and Coroners.	576	1	30/60	288
Total	387

Dated: November 13, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity (OSI), Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Advisory Board on Radiation and Worker Health (ABRWH or Advisory Board), National Institute for Occupational Safety and Health (NIOSH)

In accordance with section 10(a)(2) of the Federal Advisory Committee Act

(Pub. L. 92–463), and pursuant to the requirements of 42 CFR 83.15(a), the Centers for Disease Control and Prevention (CDC), announces the following meeting of the aforementioned committee:

Board Public Meeting Times and Dates (All times are Eastern Time): 8:15 a.m.–5:45 p.m., December 11, 2012. 8:15 a.m.–12:30 p.m., December 12, 2012.

Public Comment Times and Dates (All times are Eastern Time): 6:00 p.m.–7:00 p.m.,* December 11, 2012.

* Please note that the public comment periods may end before the times indicated, following the last call for comments. Members of the public who wish to provide public comments should plan to attend public comment sessions at the start times listed.

Place: Hilton Knoxville, 501 West Church Avenue, Knoxville, Tennessee 37902; Phone: 865–251–2573; Fax: 865–546–1716. Audio Conference Call via FTS Conferencing. The

USA toll-free, dial-in number is 1–866–659–0537 with a pass code of 9933701.

Status: Open to the public, limited only by the space available. The meeting space accommodates approximately 150 people.

Background: The Advisory Board was established under the Energy Employees Occupational Illness Compensation Program Act of 2000 to advise the President on a variety of policy and technical functions required to implement and effectively manage the new compensation program. Key functions of the Advisory Board include providing advice on the development of probability of causation guidelines which have been promulgated by the Department of Health and Human Services (HHS) as a final rule, advice on methods of dose reconstruction which have also been promulgated by HHS as a final rule, advice on the scientific validity and quality of dose estimation and reconstruction efforts being performed for purposes of the compensation program, and advice on petitions to add